Kimberlee Pita
Board Chair

Luis B. Pérez, LCSW
President & CEO

**Testimony in support of**
**H.B. No. 7125: AN ACT CONCERNING PARITY FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS, NONQUANTITATIVE TREATMENT LIMITATIONS, DRUGS PRESCRIBED FOR THE TREATMENT OF SUBSTANCE USE DISORDERS, AND SUBSTANCE ABUSE SERVICES.**

**Insurance and Real Estate Committee, Public Hearing, March 5, 2019**

Representative Scanlon, Senator Lesser, Senator Kelly, Representative Pavalock-DAmato, and Distinguished Members of the Insurance and Real Estate Committee:

My name is Suzi Craig and I am the Senior Director of Policy at Mental Health Connecticut (MHC). MHC provides community-based services across Connecticut, and we have offices in six areas – Stamford, Bridgeport, Waterbury, Torrington, Danbury, and West Hartford – providing services that support the four pillars of recovery: home, health, purpose, and community.

I am also the head of the CT Parity Coalition (www.ctparitycoalition.org), a state-wide group of 25 organizations, associations, and individuals who are rallying support for HB 7125, with recommended changes.

The CT Parity Coalition has united addiction and mental health professionals, advocacy and support groups, suicide prevention and addiction advocacy experts, therapists, professional associations, church leaders, lawyers, social workers, regional mental health boards, nurses, doctors, and individuals who have been personally affected by the lack of access or insufficient insurance coverage for mental health and addiction treatment. Many of us are here today to show our support for putting forth legislation that takes parity to the next level.

The 2008 Federal law, the Mental Health Parity and Addiction Equity Act is, conceptually, very simple: insurance coverage for mental health and addiction care should be no more restrictive than insurance coverage for any other medical condition. However, the Federal Parity Law is very complex, and implementation of the law can be challenging.

According to the December 2017 Milliman report, "Addiction and Mental Health vs Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates," CT was identified as the state with the highest disparity between physical and behavioral healthcare in terms of the proportion of office visits that are out-of-network. Significant disparities were also identified in inpatient care and payments to behavioral health providers compared with primary care providers. Connecticut was once a leader in parity law. It's time that we reclaimed our position and pass legislation that will ultimately lead to saving more lives and lowering long-term health care costs.

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That said, for HB 7125 to be effective in its ability to generate the report outs that we need to achieve clarity on the disparities that exist, we are asking that you change the language to specifically follow the analysis steps that were created for a national model by leading parity experts at the Kennedy Forum, the American Psychiatric Association, and the Parity Implementation Coalition. This approach was also adopted by United States Department of Labor in its Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act, released last April.

This level of transparency and accountability as specifically laid out in the national model is necessary. The CT Parity Coalition is advocating that Connecticut follow suit and:

- Establish reporting requirements for insurers to demonstrate how they design and apply their managed care tactics, so regulators can determine if there is compliance with the Federal law

- Specify how state insurance departments can implement parity and then report on their activities

See the addendum below for specific language changes that we recommend. Without these specific steps there is no other way to know if private insurers are in compliance with the federal law.

HB 7125 must exist if we are to gain clarity on parity compliance and, ultimately, ensure that the lives and consumer rights of our Connecticut friends and neighbors are protected. Again, these reporting requirements are essential to have in the bill so that this next iteration of parity compliance can be achieved.

Nationally, 20-30 states are considering, currently adopting, or have adopted this legislation to standardize compliance with the federal law. Please support the work that has been done on the national stage, and here at home, to ensure that Connecticut enacts HB 7125 into law.

I want to thank you for supporting legislation that will encourage Connecticut's ability to invest in our friends and neighbors, and to strive to achieve a more equitable approach to health.

Thank you for your time and for your service,

Suzi Craig
Senior Director of Policy

mental health connecticut

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**ADDENDUM: PLEASE SEE ADDITIONS BELOW (IN *BOLD ITALICS*) IN SECTION (3) THAT WILL ALLOW FOR HB 7125 TO FOLLOW THE NATIONAL MODEL OF FEDERAL PARITY COMPLIANCE:**

(3) The results of an analysis concerning the processes, strategies, evidentiary standards and other factors that such health carrier used in developing and applying the criteria described in subdivision (1) of this subsection and each nonquantitative treatment limitation described in subdivision (2) of this subsection. The results of such analysis shall, at a minimum:

(A) Disclose each factor that such health carrier considered, regardless of whether such health carrier rejected such factor, in (i) designing each nonquantitative treatment limitation described in subdivision (2) of this subsection, and (ii) determining whether to apply such nonquantitative treatment limitation;

(B) Disclose the evidentiary standards that such health carrier applied in considering the factors described in subparagraph (A) of this subdivision;

*(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to medical and surgical benefits;*

*(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes or strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and*

(E) Disclose information that, in the opinion of the Insurance Commissioner, is sufficient to demonstrate that such health carrier (i) equally applied each nonquantitative treatment limitation described in subdivision (2) of this subsection to (I) mental health and substance use disorder benefits, and (II) medical and surgical benefits, and (ii) complied with (I) sections 2 and 3 of this act, (II) sections 38a-488a and 38a-514 of the general statutes, and (III) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder.